



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Global Molecular Labs

Respondent Name

TASB Risk Mgmt Fund

MFDR Tracking Number

M4-17-3430-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

July 24, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The charges referenced herein were filed with the Carrier and denied for "pre-certification or authorization or notification absent and information submitted does not support this level of service." We believe this claim has been denied arbitrarily and respectfully request dispute resolution in this matter.

Amount in Dispute: \$4,875.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Fund denied the bill as the medical documentation submitted does not support the number of classes being studied."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 17,2016	G0482	\$4,875.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service

- 197 – Payment adjusted for absence of precertification/authorization
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- W3 – Additional payment made on appeal/reconsideration

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of \$4,875.00 for code G0482 - *Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed, rendered on October 17, 2016.*

The insurance carrier denied disputed services with claim adjustment reason code 150 – “Payment adjusted because the payer deems the information submitted does not support this level of service.” 28 Texas Administrative Code §134.203 (b) states,

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

- (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

Review of the submitted code on the medical bill finds within the narrative for code G0482, “Drug test(s)... 15-21 drug class(es).” Review of the document titled, “Final Report” indicates eleven classes of testing. As the narrative of the code used to submit the medical claim is not supported by the number of classes tested, the carrier's denial is supported.

2. Based on the above the requirements of 28 Texas Administrative Code 134.203 (b) were not met. No additional payment is ordered.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 18, 2017 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.